MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

05114

Reg. Dist. No. 2-02

1. PLACE OF DEATH:
County: Kent
City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yrs.
Hospital, institution, or street address where death occurred: 213 S. Queen St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 213 S. Queen St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Carrie Adams

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C.	Widow

6.(b) Name of husband or wife (Late) John Adams
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Sept. 16 1871

8. AGE: Years 73 | Months 7 | Days 26 | If less than one day ____ hrs. ____ min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business: home
12. FATHER — Name: James Henry Ringold
13. FATHER — Birthplace: Chestertown, Maryland
14. MOTHER — Maiden name: Susquanna Wickes
15. MOTHER — Birthplace: Balto. Maryland
16. Informant: Mrs. Anna Ford
Address: 213 S. Queen St. Chestertown Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/16/45 (month) (day) (year)
Cemetery or crematory: Big Woods Cemetery
Location: Near - Still Pond, Kent Co. Md.
18. Funeral director: Marvin V. Williams
Address: Chestertown, Maryland
19. May 16, 1945 (Date rec'd by registrar) Clara L. Barnes, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12 1945, at 1:00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr - 10 1945 to May 12 1945
and that I last saw h[illegible] alive on May 11 1945

Immediate cause of death	DURATION
Organic heart trouble	
Due to: A.B.P. and general debility	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H P Cohland M. D. or other
Address: Chestertown Date signed 5/16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17)

CERTIFICATE OF DEATH

05115

Reg. Dist. No. 202

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Kent
City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 202 S. Front
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 202 S Front
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: John Wilson Blount

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W	Married

6.(b) Name of husband or wife: Arabella Blount
6.(c) If alive, give age: 76 years

7. Birth date of deceased (mo., day, yr.): January 19 1865

8. AGE:

Years	Months	Days	If less than one day
80	4	2	...hrs. ...min.

9. Birthplace: Queenstown Queen Anne Co. Md.
(Town, county, and state)
10. Usual occupation: Waterman (Retired)
11. Industry or business:

FATHER
12. Name: Charles B. Blount
13. Birthplace: Queen Anne Co. Md.

MOTHER
14. Maiden name: Eleanor Willson
15. Birthplace: Kent Co. Maryland

16. Informant: Mrs. J. W. Blount (Wife)
Address: 202 S. Front St. Chestertown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/23/45 (month) (day) (year)
Cemetery or crematory: Chestertown
Location: Chestertown Maryland.
18. Funeral director: Maggie V. Williams
Address: Chestertown Maryland.

19. May 23, 1945 (Date rec'd by registrar) Clara S. Barnes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 21 1945, at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-1- 1944, to 1-20- 1945
and that I last saw him alive on 1-20 1945

Immediate cause of death	DURATION
Edema of Lungs	1 day
Due to: Arteriosclerosis	2
	1
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ...Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: ...Injured at work?

23. SIGNATURE: H G Simpers M. D. or other
Address: Chestertown Date signed: 1-21-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (462)

CERTIFICATE OF DEATH

05116

Reg. Dist. No. 202

1. PLACE OF DEATH:

County: Kent

City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
200 Byron Court

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Kent

City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 200 Byron Court
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Mary Lizzie Burden

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	Widowed

6.(b) Name of husband or wife: John Burden

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): ? ? I869

8. AGE: Years	Months	Days	If less than one day
76	?	?	..... hrs. ..... min.

9. Birthplace: Kent Co. Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Ped Graves
13. Birthplace: Maryland

MOTHER
14. Maiden name: Unknown
15. Birthplace

16. Informant: Duley Burden (son)
Address: 200 Byron Court - Chestertown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 30, I945 (month) (day) (year)

Cemetery or crematory: Sandy Bottom Cem. (Col)

Location: Near Chestertown, Md.

18. Funeral director: J. Willis Wells

Address: Chestertown, Md.

19. May 27 1945 (Date rec'd by registrar) Clara L. Barnes, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5-27- 19 45, at 1 80 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-1- 19 45 to 4-25 19 45 and that I last saw h 21 alive on 5-25 19 45

Immediate cause of death	DURATION
Cancer of stomach	
Due to —	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: H P Bohland M. D. or other

Address: Chestertown Date signed: 5-28-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

37
20
77

Evidence for change of age is shown on FILM No. G 95 MAY 28 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

05117 701
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Kent
City or town Worton 2nd Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 75 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Kent
City or town Worton 2nd Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Worton 2nd Rural
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Herman Merritt Crew.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Hettie Alexia Crew
6.(c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Nov 3 1888

8. AGE:	Years	Months	Days	If less than one day
56	57	6	10	....hrs. ....min.

9. Birthplace Kent Co Md. (Town, county, and state)
10. Usual occupation Farming
11. Industry or business Farming

FATHER
12. Name William Hanson Crew
13. Birthplace Kent Co Md.

MOTHER
14. Maiden name Laura Louise Crew
15. Birthplace Maryland

16. Informant Arthur Crew
Address Worton 2nd Rural

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 15 1945 (month) (day) (year)
Cemetery or crematory Still Pond Md
Location Still Pond Md

18. Funeral director B.B. Fellows
Address Still Pond Md

19. May 15 1945 J.M. Clark
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1945 at 9:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1942 to May 13 1945
and that I last saw him alive on May 13 1945
Immediate cause of death Cerebral Hemorrhage

	DURATION
Due to Arteriosclerosis	
Due to Hypertension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ✓
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ✓ Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ✓
Means of injury Injured at work?

23. SIGNATURE Owen Edwin Dedman M.D.
M. D. or other
Address Box 19 Betterton Md Date signed May 15 1945

T Haynes

Evidence for change of age is shown on

FILM No. G 9 5 JUN 5 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 51-2

CERTIFICATE OF DEATH

05118

Reg. Dist. No. 202

1. PLACE OF DEATH:
County: Kent
City or town: Morton Md (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months
Hospital, institution, or street address where death occurred: —
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Morton Md (If outside city or town limits, write RURAL and give nearest town)
Street No. — (If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME Charles Henry Crowding.

3. (b) Social Security Number —

4. Sex: Male
5. Color or race: W.
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Agnes Crowding
6.(c) If alive, give age 65 years
7. Birth date of deceased (mo., day, yr.): Jan 15. 1880
8. AGE: Years 65 66 Months 4 Days — If less than one day ... hrs. ... min.
9. Birthplace: Morton Md (Town, county, and state)
10. Usual occupation: Farming
11. Industry or business: Farm
FATHER 12. Name: Jacob Beaston Crowding
FATHER 13. Birthplace: Delaware
MOTHER 14. Maiden name: Annie Robinson
MOTHER 15. Birthplace: Delaware
16. Informant: Agnes Crowding
Address: Morton Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 24 1945 (month) (day) (year)
Cemetery or crematory: Still Pond
Location: Still Pond Md
18. Funeral director: B.R. Fellows
Address: Still Pond Md.
19. May 24 1945 (Date rec'd by registrar) Clara S. Barnes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 22 1945, at 3:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1944, to May 22 1945; and that I last saw him alive on May 21 1945
Immediate cause of death: Cancer Carcinoma Prostate Metastasis to Spine and adjacent Pelvic Bones — DURATION: 2 yrs
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings of operations: None
Date of op.
Autopsy results: No
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of
Where did injury occur? None (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?
23. SIGNATURE: Frank Hines M.D. (M. D. or other)
Address: Chestertown Md Date signed May 23/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (12-A)

CERTIFICATE OF DEATH

05119

Reg. Dist. No. 2 0 2 J

1. PLACE OF DEATH:
County: Kent
City or town: Chestertown [redacted]
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 hours
Hospital, Institution, or street address where death occurred:
Kent and Queen Anne's Hospital
How long in hospital or institution? 4 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Rural, Worton, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Judith Marie Deringer

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 30, 1945

8. AGE: Years | Months: 3 | Days: 13 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Chestertown, Kent, Maryland
(Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER
12. Name: Edmon H. Deringer
13. Birthplace: near Kennedyville, Kent Co., Maryland

MOTHER
14. Maiden name: Ann Williams
15. Birthplace: Worton, Kent Co; Maryland

16. Informant: Hosp. Records
Address: Chestertown, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/13/45 (month) (day) (year)
Cemetery or crematory: Chester
Location: Chestertown, Maryland

18. Funeral director: Marion V. Williams
Address: Chestertown, Maryland

19. May 13, 1945 (Date rec'd by registrar) Clara D. Barnes, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 11, 1945, at 6:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 11, 1945, to May 11, 1945
and that I last saw her alive on May 11, 1945

Immediate cause of death	DURATION
Volvulus of mid portion of small intestine	30 hours
Due to	
Due to	
Other conditions	

(Include pregnency within 3 months of death)

Major findings of operations: Volvulus of mid-portion of small intestine Date of op. 5-11-45
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

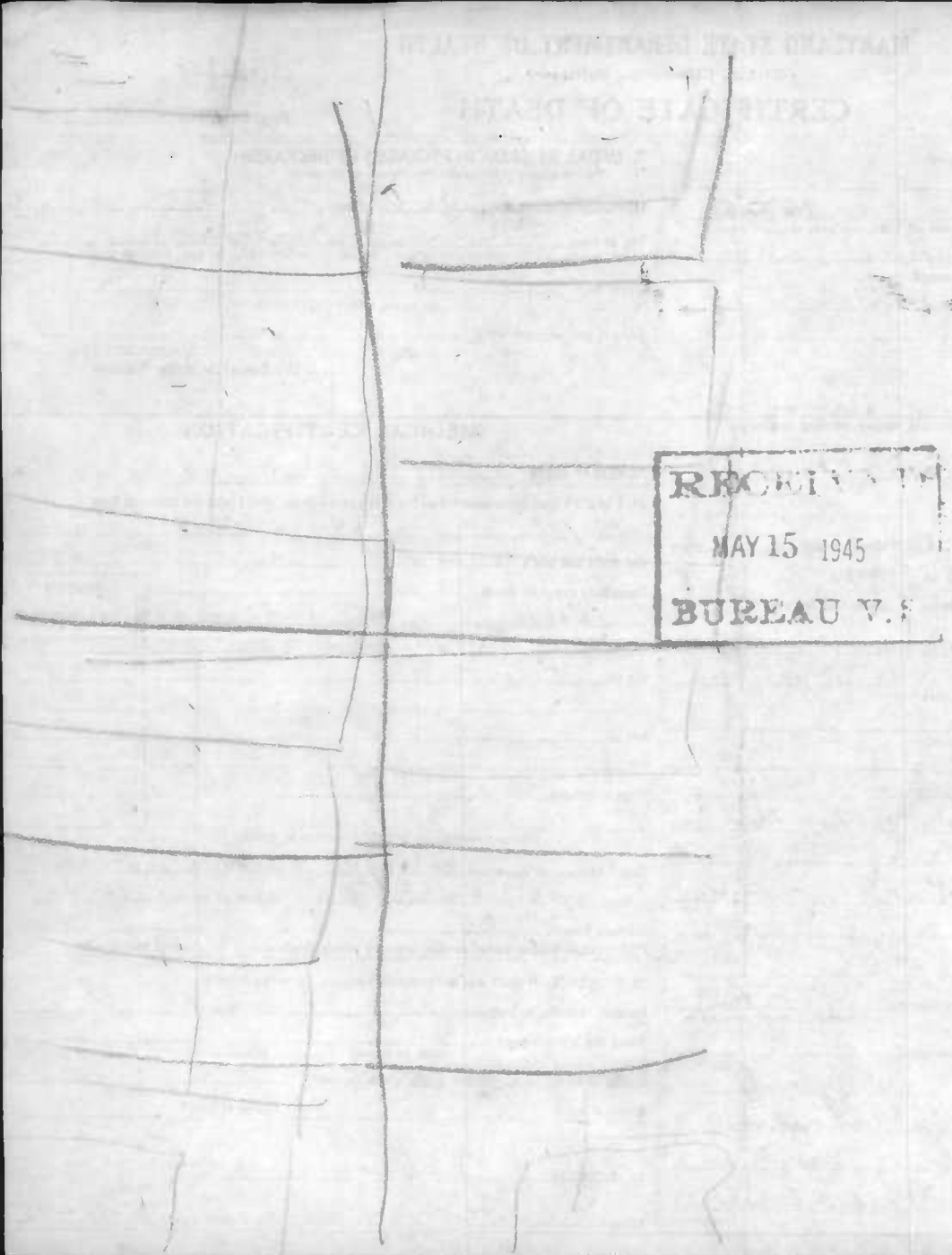
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: A. E. Dick, M.D.
M. D. or other
Address: Chestertown, Md. Date signed 5-11-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15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MAY 15 1945
BUREAU V.S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05120

Reg. Dist. No. 202

1. PLACE OF DEATH:
County: Kent
City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 week
Hospital, Institution, or street address where death occurred: Kent and Queen Anne's General Hosp.
How long in hospital or institution? 1 week

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Rock Hall Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Edwards
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Dora Dicke Fields

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	White	widowed

6.(b) Name of husband or wife: Wesley Fields
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Oct 1873

8. AGE: Years	Months	Days	If less than one day
71	7	?	..... hrs. ..... min.

9. Birthplace: Kent Co, Md. (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business
FATHER 12. Name: Theodore Dicke
13. Birthplace: Maryland
MOTHER 14. Maiden name: Hester Hamilton
15. Birthplace: Maryland
16. Informant: Mrs T. D. Bowers
Address: Chestertown, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 11, 1945 (month) (day) (year)
Cemetery or crematory: Chester Cem.
Location: Chestertown, Md.
18. Funeral director: J. Willis Wells
Address: Chestertown, Md.
19. May 10, 1945 (Date rec'd by registrar) Clara L. Barnes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 8 1945, at 11.45 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1945, to May 8 1945 and that I last saw h... alive on 5-8- 1945

Immediate cause of death	DURATION
Rocky Mountain spotted fever	
Due to: Hypertension	
Due to: Chronic Endo-Myocarditis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE: Albert A Burgard M. D. or other
Address: Rock Hall, Md. Date signed 5/9/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-0)

05121

CERTIFICATE OF DEATH

Reg. Dist. No. 201

1. PLACE OF DEATH:
County: Kent
City or town: Still Pond
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Still Pond Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Kate Smith Ford

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Widowed

6.(b) Name of husband or wife: Edward L. Ford
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Apr 27 1864

8. AGE: Years: 81 | Months: | Days: 28 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Delaware
(Town, county, and state)

10. Usual occupation: retired

11. Industry or business: home

FATHER
12. Name: George H Smith
13. Birthplace: Chesterville Md

MOTHER
14. Maiden name: Mary Hewlins
15. Birthplace: Delaware

18. Informant: Wallace Ford
Address: Still Pond Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 25 1945 (month) (day) (year)
Cemetery or crematory: Still Pond
Location: Still Pond Md

18. Funeral director: B R Fellows
Address: Still Pond Md

19. May 25 1945 (Date rec'd by registrar) J M Clark Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 22 1945 at 3:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 16th 1945 to May 22 1945 and that I last saw h.. alive on May 22nd 1945

Immediate cause of death	DURATION
Chronic Interstitial Nephritis.	years.
Due to	
Due to	
Other conditions: Complications.	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: L. P. Atwell M. D. or other
Address: Still Pond Date signed 5/25/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

CERTIFICATE OF DEATH

05122 T

Reg. Dist. No. 202

1. PLACE OF DEATH:
County: Kent
City or town: Chestertown (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 hours
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 8 hours

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Kennedyville R D #1 (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: William F. Hamilton — **3.(b) Social Security Number:**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Sept 6. 1925

8. AGE: Years: 19 | Months: 8 | Days: 1 | If less than one day: hrs. min.

9. Birthplace: Kent Co. Md (Town, county, and state)
10. Usual occupation: Farm Laborer
11. Industry or business: Farming
FATHER 12. Name: James Hamilton
FATHER 13. Birthplace: Kent Co Md
MOTHER 14. Maiden name: Lida Newnam
MOTHER 15. Birthplace: Kent Co Md
16. Informant: Jas Hamilton
Address: Kennedyville Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/9/45 (month) (day) (year)
Cemetery or crematory: Crumpton
Location: Crumpton Md
18. Funeral director: Edward Tellburg
Address: Millington Md.
19. May 9 1945 (Date rec'd by registrar) Clara L. Barnes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 7 1945 at 12 10 M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 6 1925 to May 7 1945 and that I last saw ... alive on May 7 1945; that death occurred at 12 10 M.; that the cause of death was as follows:

	DURATION
Immediate cause of death: Med Exam Fracture Skull	7hr
Due to: Hemorrhage Brain	hour
Due to: Auto Accident	
Other conditions:	

(Include pregnancy within 3 months of death)
Major findings of operation: Fracture Skull Date of op. May 6 1945
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide or homicide? Accident Date of May 6/45
Where did injury occur? Mt Custrale (City or town) Md (County) (State) Public Road
Injured at home, farm, industry, public place (where?)
Means of injury: Auto Injured at work? No
23. SIGNATURE: Faith Hines M.D. Med Exam Kent Co
Address: Chestertown Md Date signed: May 7/45

VS A1F

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

05123

Reg. Dist. No. 2,02

1. PLACE OF DEATH:
County: Kent
City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 days
Hospital, institution, or street address where death occurred: Kent & Queen Anne Hosp
How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Maryland County: Kent
City or town: Chestertown Rd ned
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William H. Hargest

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Mrs. Harriett ? Hargest
6.(c) If alive, give age: Deceased years

7. Birth date of deceased (mo., day, yr.): March 4. 1851

8. AGE: Years: 94 | Months: 2 | Days: 26 | If less than one day: hrs. min.

9. Birthplace: Baltimore md
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER
12. Name: Thomas Hargest
13. Birthplace: Balto. md

MOTHER
14. Maiden name: Emeline Ann Leach
15. Birthplace: Balto. md

16. Informant: Mrs. Edward Hargest
Address: 1636 Asquith St, Balto, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 1. 1945 (month) (day) (year)
Cemetery or crematory: Crumpton
Location: Crumpton Md.

18. Funeral director: Edgar L. Lane
Address: Church Hill Md.

19. June 1 1945 (Date rec'd by registrar) Clara L. Barnes. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 30 1945 at 7:45 P M

I CERTIFY that death occurred on the date above stated; that I attended deceased from May 20 1945 to May 30 1945
and that I last saw h[illegible] alive on May 30 1945

	DURATION
Immediate cause of death: Myocardial Infarction	Several yrs
Due to: Arteriosclerosis	Several yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of
Where did injury occur? None (City or town) (County) (State)
Injured at home, farm, todustry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Mack Hall MD M. D. or other
Address: Chestertown md Date signed: June 2 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15


RECEIVED
JUN 4 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (140)

CERTIFICATE OF DEATH

05124 T

Reg. Dist. No. 202

1. PLACE OF DEATH:

County: Kent

City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Xxdayx

Hospital, Institution, or street address where death occurred:
Kent & Queen Anne Co. Hospital

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infante give residenee of mother)

State: Md. County: Kent

City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 116 Cannon St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Dorothy Hopkins Keyser

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Medford Keyser

Living 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 2, 1915

8. AGE: Years	Months	Days	If less than one day
30	2	9	..... hrs. ..... min.

9. Birthplace: Centreville, Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: William Hopkins
13. Birthplace: Maryland

MOTHER
14. Maiden name: Effie Fairall
15. Birthplace: Maryland

16. Informant: Hospital records
Address: Chestertown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 13, 1945 (month) (day) (year)

Cemetery or crematory: Saint Paul Cem.

Location: Near Chestertown, Md.

18. Funeral director: J. Willis Wells

Address: Chestertown, Md.

19. May 11 19 45 (Date rec'd by registrar) Cesar L. Barnes. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 11, 45 at 6:15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Septicemia	
Due to: Incomplete Abortion	
Cause Undetermined.	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: Above - Performed by Howard J. Madden M.D.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Howard J. Madden, M.D. M. D. or Other

Address: 700 Fleet Street Date signed: May 11, 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

63125

Reg. Dist. No. 202

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Kent
City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Cannon St. Ext.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Kent
City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Zoa Coleman Nickerson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: David T. Nickerson

7. Birth date of deceased (mo., day, yr.): Feb. 19 1915

B.(c) If alive, give age: 34 years

8. AGE: Years	Months	Days	If less than one day
30	2	25	....hrs. ....min.

9. Birthplace: Kent Co. Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Clifton Coleman
13. Birthplace: Md.

MOTHER
14. Maiden name: Eunice Elliottt
15. Birthplace: Kent Co. Md.

16. Informant: Miss. Helen L. Coleman
Address: Chestertown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 16. 1945 (month) (day) (year)
Cemetery or crematory: Chester Cem.
Location: Chestertown, Md.

18. Funeral director: J. Willis Wells
Address: Chestertown, Md.

19. May 15 1945 (Date rec'd by registrar) Clare L. Barnes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13.1945 19.... at 2.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1944 to May 13.1945 and that I last saw h...er alive on May 13.1945

Immediate cause of death: Carcinoma Breat Spine with General Metastasis — DURATION: 9 Months

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma as above

Date of op.:

Autopsy results: Not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Frank Bird M.D.
Address: Chestertown Md M. D. or other
Date signed: May 14.19

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-2)

CERTIFICATE OF DEATH

05126

Reg. Dist. No. 2021

1. PLACE OF DEATH:
County: Kent
City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 days
Hospital, Institution, or street address where death occurred:
Kent and Queen Anne's Hospital
How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Galena
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Robert Schultz

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Oct. 26 1928

8. AGE: Years: 16 | Months | Days | If less than one day: ____ hrs. ____ min.

9. Birthplace: Galena, Kent, Maryland (Town, county, and state)

10. Usual occupation: Student

11. Industry or business

FATHER
12. Name: Herman Schultz
13. Birthplace: Kent County, Md

MOTHER
14. Maiden name: Ella O'Neil
15. Birthplace: Cecil County, Md

16. Informant: Hosp. records
Address: Chestertown, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 16 1945 (month) (day) (year)
Cemetery or crematory: Galena
Location: Galena Md
18. Funeral director: Edward Pillow
Address: Millington Md

19. May 15 1945 (Date received by registrar) Clara S. Barnes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13 1945 at 7 20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 6 1945 to May 13 1945
and that I last saw him alive on May 13 1945

Immediate cause of death	DURATION
Fractured Skull, basilar, & extensive brain damage	7 days
Due to Automobile accident	
Punctured left lung	7 days
Due to Fractured left clavicle	
Other conditions Fractured jaw, lower left	7 days

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 5-6-45
Where did injury occur? Kent (City or town) Maryland (County) (State)
Injured at home, farm, industry, public place (where?) Road
Means of injury: Auto accident Injured at work? No

23. SIGNATURE: A. C. Dick, M.D. (M. D. or other)
Address: Chestertown, Md. Date signed 5-13-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of age is shown on FILM No. G 95 JUN 5 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (89-a)

CERTIFICATE OF DEATH

05127 201

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Kent

City or town near Kennedyville Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

7 years

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 5 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Kent

City or town Rural near Kennedyville Md

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Kennedyville Md.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Gertrude Stanley

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	C	Widowed

6 (b) Name of husband or wife Douglas Stanley

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) May 22 1891

8. AGE: Years	Months	Days	If less than one day
54	53	3	____ hrs. ____ min.

9. Birthplace Kent Co Md (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Farm

FATHER 12. Name James Bowers

FATHER 13. Birthplace Kent Co

MOTHER 14. Maiden name Edell Wilson

MOTHER 15. Birthplace Colemans

16. Informant James Bowers

Address Chestertown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 29 1945 (month) (day) (year)

Cemetery or crematory Mt Zion

Location Still Pond Md

18. Funeral director B R Fellows

Address Still Pond Md.

19. May 29 1945 (Date rec'd by registrar) J M Cook Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1945, at 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 3 1945, to May 25 1945, and that I last saw her alive on May 21 1945.

Immediate cause of death	DURATION
Cerebral Hemorrhage	7 hrs
Due to Arteriosclerosis	several yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE Merritt Bowers M. D. or other

Address Centreville Md Date signed 5/27/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

Reg. Dist. No. 05128 202

1. PLACE OF DEATH:
County: Kent
City or town: Chestertown, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 hours
Hospital, Institution, or street address where death occurred:
Kent & Queen Annes Hospital
How long in hospital or institution? 7 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Queen Anne
City or town: Maryhel
(If outside city or town limits, write RURAL and give nearest town)
Street No. R. R. #1
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Louis High Teat

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 12, 1945

8. AGE: Years | Months | Days | If less than one day: 7 hrs. min.

9. Birthplace: Chestertown, Kent, Maryland (Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Earl Benjamin Teat
13. Birthplace: Bowlay, Maryland

MOTHER
14. Maiden name: Anna Elizabeth Hersey
15. Birthplace: Millington, Md

16. Informant: Mother
Address: Maydel, Md - R.D. 1

17. (Burial, cremation, or removal. Which?) Date thereof: May 12, 1945 (month) (day) (year)
Cemetery or crematory:
Location:

18. Funeral director: Father
Address:

19. May 12 1945 (Date rec'd by registrar) Clara L. Barnes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5-12 1945 at 2:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-12 1945 to 5-12 1945 and that I last saw h.e.r. alive on 5-12 1945

Immediate cause of death	DURATION
Premature infant	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: A. C. Dick, M.D. M. D. or other
Address: Chestertown, Md Date signed: 5-12-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (166)

CERTIFICATE OF DEATH

F 5129

Reg. Dist. No. 200

1. PLACE OF DEATH:
County Kent
City or town Millington R 2 (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Kent
City or town Millington R 2 (If outside city or town limits, write RURAL and give nearest town)
Street No. 8 (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Walter Clay Thomas

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	single

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) August 24 1942

8. AGE: Years 1 Months Days If less than one day ____ hrs. ____ min.

9. Birthplace Kent Co Md (Town, county, and state)

10. Usual occupation From birth

11. Industry or business

FATHER
12. Name Wayman Thomas
13. Birthplace Kent Co Md

MOTHER
14. Maiden name Lillie Brown
15. Birthplace Kent Co Md

16. Informant Wayman Thomas
Address Millington R 2 Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 16 1945 (month) (day) (year)
Cemetery or crematory Chesterville
Location near Millington Md

18. Funeral director Edward Fellows
Address Millington Md

19. 5/15 1945 (Date rec'd by registrar) M. Davis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1945 at 4 P M

21. CERTIFY that death occurred on the date above stated, that I attended deceased from ____ 19__ to ____ 19__ and that I last saw h__ alive on ____ 19__

Immediate cause of death Gunshot Wound Head

DURATION

Due to Brain

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide? Homicide Date of May 13 1945

Where did injury occur? Millington R 2 Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Pistol Injured at work? No

How did injury occur? Gun shot wound Head. Died in Md

23. SIGNATURE ____ M. D. or other

Address Chestertown Md Date signed Dec 11 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

05130

CERTIFICATE OF DEATH

Reg. Diat. No. 202

1. PLACE OF DEATH:
County Kent
City or town Chestertown, (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years
Hospital, institution, or street address where death occurred: Kent + Queen Annes Hospital Chestertown, Md
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Kent
City or town Chestertown (If outside city or town limits, write RURAL and give nearest town)
Street No. 502 High Street (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Trew

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) MAY 27, 1877

8. AGE: Years 67 | Months 11 | Days 6 | If less than one day ..... hrs. ..... min.

9. Birthplace Kent, Maryland (Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business

FATHER
12. Name Joseph Trew
13. Birthplace Kent County, Maryland

MOTHER
14. Maiden name Anna Rebecca Trew
15. Birthplace Kent County, Maryland

16. Informant Hospital Records
Address Chestertown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof MAY 5 1945 (month) (day) (year)
Cemetery or crematory Chester Cemetery
Location Chestertown, Md.

18. Funeral director J. Willis Wells
Address Chestertown, Md.

19. May 3, 1945 (Date rec'd by registrar) Clara L. Barnes, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 1945 at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 29 1945 to May 3 1945 and that I last saw her alive on May 3 1945

	DURATION
Immediate cause of death: Diabetes	5 years
Diabetic gangrene left leg	5 days
Due to	
Due to	
Other conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE A. C. Dick, M.D. M. D. or other
Address Chestertown, Md. Date signed 5-3-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING